Hospital Based Ambulatory Surgery Facilities Certified Under Article 28 of the Public Health Law

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, and space occupancy and plant overhead costs, and an economic trend factor is applied to make the prices prospective. [~~The agency assures that it is in compliance with the upper payment limit requirement mandated by 42 CFR 447.321 and pays no more for those services than would be payable to providers for comparable services under Medicare.~~]

Freestanding Diagnostic and Treatment Centers

Facilities Certified Under Article 28 of the Public Health Law as Freestanding Ambulatory Centers

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, and space occupancy and plant over-head costs, and an economic trend factor is applied to make the prices prospective. The agency may pay the usual and customary rates of such medical facilities or approved services but must not pay more than the prevailing rates for comparable services in the geographic area.

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Hospital Based Outpatient Department

**Facilities Certified Under
Article 28 of the Public Health Law**

**Services for AIDS and HIV
positive patients**

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

**Freestanding Diagnostic
and Treatment Centers**

**Facilities Certified Under
Article 28 of the Public Health
Law As Freestanding
Diagnostic and Treatment Centers**

Services for AIDS and HIV positive patients

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, 1996.

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TN 95-25 Approval Date FEB 11 1999
Supersedes TN 91-35 Effective Date APR 1 1995

Hospital Based Outpatient Department

Facilities Certified Under Article 28 of the Public Health Law as Hospital-Based Outpatient Departments

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women. for each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

Freestanding Diagnostic and Treatment Centers

Facilities Certified Under Article 28 of the Public Health Law as Freestanding Diagnostic and Treatment Centers

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, 1996.

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New York
2(c)(i)

Attachment 4.19B
SPA 95-25

Comprehensive Primary Care Services

Voluntary Non-Profit and Publicly Sponsored Diagnostic and Treatment Centers Certified Under Article 28 of the Public Health Law

An allowance will be established annually and added to Medicaid rates of payment for certified agencies which can demonstrate a financial shortfall as a result of providing comprehensive primary care services to a disproportionate share of uninsured low-income patients. Losses will be calculated by applying the current Medicaid payment rate to base year units of service to uninsured low-income patients, offset by related out-of-pocket patient receipts, subsidy grants and State aid deficit financing to publically-sponsored facilities. An annual agency loss coverage will be established by applying calculated losses to a nominal loss coverage ratio scale within the limits of pool allocations to public and non-public agencies.

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APR 1 1995

New York
2(c)(ii)

Attachment 4.19-B
(10/99)

Transitional Supplemental Payments

For the period October 1, 1999 through December 31, 1999, the Commissioner of Health shall make supplemental medical assistance payments to qualified voluntary not-for-profit health care providers that are: freestanding diagnostic and treatment centers (D&TCs) that qualify for distributions under the state's comprehensive diagnostic and treatment centers indigent care program or indicate on the cost reports submitted to the state that they receive funding under section three hundred thirty-three of the Federal Public Health Services Act for health care for the homeless, freestanding diagnostic and treatment centers that operate approved programs under the state Prenatal Care Assistance Program, licensed facilities sponsored by a university or dental school which have been granted an operating certificate to provide dental services, or licensed freestanding family planning clinics. These supplemental payments reflect additional costs associated with the transition to Managed Care. These providers will be eligible to receive a supplemental payment if the following criteria are met. The provider's number of Medicaid visits in the base year (1998) equals or exceeds 25 percent of its total number of visits and its number of visits for Medicaid Managed Care enrollees equals or exceeds three percent of its total number of Medicaid visits during the base year. Providers meeting these criteria shall receive a supplemental payment equal to a proportional share of the total funds available not to exceed six million dollars. This share shall be based upon the ratio of a provider's visits from medical assistance recipients enrolled in Managed Care during the 1998 base year to the total number of visits to all such qualified providers by medical assistance recipients enrolled in managed care during the base year.

TN 99-31 Approval Date JAN 7 2000

Supersedes TN New Effective Date OCT 1 1999

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TYPE OF SERVICE

Products of Ambulatory Care (PACS) for Hospital-Based Clinics and Freestanding Diagnostic and Treatment Centers [(August 1, 1990 through July 31, 1991)]

METHOD OF REIMBURSEMENT

The [products] Products of Ambulatory Care (PACs) Reimbursement Program uses a prospective reimbursement method associated with resource use patterns to insure that ambulatory services are economically and efficiently provided, and to provide incentives to foster continuity of care and treatment for patients. All participating providers, both hospital based clinics and freestanding diagnostic and treatment centers, are placed under a uniform, prospective, modified priced based system. The methodology is based upon the assignment of an ambulatory care visit into one of 24 mutually exclusive PAC groups. Under the reimbursement method, facility specific payment rates are established for each of the 24 PAC groups. Each rate in the payment model is comprised of two components -- a case mix related price component and a facility component. The price component includes values for labor, ancillaries and medical supplies for which values are based upon current market prices. The facility specific cost components include pharmacy, facility, teaching and capital costs, and are based on a providers reported historical costs subject to ceiling limitations where applicable. Pharmacy and routine capital costs are fully reimbursed, although they are subject to desk audit adjustments.

The PAC payment method is an alternative to the prospective average cost per visit reimbursement method used for non - participating hospitals and diagnostic and treatment centers. There are unique

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TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Products of Ambulatory Care (PACS) for Hospital-Based Clinics and Freestanding Diagnostic and Treatment Centers [(August 1, 1990 through July 31, 1991)]	features present in the PACS reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the submission of patient encounter data by providers to the New York State Department of Health, financial responsibility by providers for selected laboratory and other ancillary procedures and Medicaid Revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with. Hospital-based clinics and freestanding diagnostic and treatment centers seeking PACs reimbursement are required to enter into a Memorandum of Participation with the New York State Department of Health.

TN 91-63 Approval Date OCT 31 1991

Supersedes TN 90-38 Effective Date AUG 1 1991

TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Ambulatory Services in Facilities Certified Under Article 16 of the State Mental Hygiene Law:	
OMRDD Clinic Treatment Program (Programs certified by OMRDD pursuant to 14 NYCRR Part 679)	[Flat fee developed by OMRDD and approved by Division of Budget] For free standing out patient providers, OMRDD will establish statewide cost related flat fees. Fees will be assigned based on provider specific actual base year costs or budgets which correspond to the fiscal cycle of the provider. All fees are subject to approval by the Division of the Budget.
OMRDD Clinic Day Treatment Program (Programs certified by OMRDD pursuant to 14 NYCRR Part 690)	Site specific, variable, per diem fees, which are cost related and developed as follows:

Fee Setting

(1) For the purpose of setting the Day Treatment fee, units of service shall include the total number of half day units of service (more than three hours but less than five hours), [and] the number of full day units of service (five hours or more) and less than half day units of services (such as in the amount of one and a half hour (1 1/2)). Units of service are billable in the above amounts. Billable services include the initial contact visit, [for] enrollment for completing a preliminary screening, and services for individuals formally admitted to the Day Treatment program.

(i) Units of service for the fee setting calculation shall utilize projected or actual units of service as follows:

(a) For non-State operated Day Treatment programs in Regions II or III, including those programs in Region I designated or elected to a Region II or III reporting year-end and fiscal cycle, the April 1, 1991 through December 31, 1991 fee setting calculation shall utilize actual units of service from the January 1, 1988 through December 31, 1988 cost report. For non-State operated Day Treatment programs in Region I, including those programs in Regions II and III designated or elected to a Region I reporting year-end and fiscal cycle, the July 1, 1991

to June 30, 1992 fee setting calculation shall utilize actual units of service from the July 1, 1988 through June 30, 1989 cost report. For State operated Day Treatment programs, the April 1, 1991 through March 31, 1992 fee setting calculation may utilize actual units of service from the April 1, 1989 through March 31, 1990 cost report.

(b) For the January 1, 1992 through December 31, 1992, April 1, 1992 through March 31, 1993 and July 1, 1992 through June 30, 1993 fee setting calculations, and thereafter actual units of service shall be from the [most recent] cost report submitted two years prior to the period for which the fee is being set. For programs for which OMRDD has not received such cost report at the time of the fee-setting calculation, OMRDD shall utilize the units of service paid for through the Medicaid Management Information System (MMIS) during the required cost report period.

(c) Projected units of service shall mean the estimated monthly attendance multiplied by the expected number of days the program will be open for each month. This computation shall be made for each month, [and] summed for the number of months in the fee period and annualized. Projected units of service will be used in the absence of actual units of service from cost reports identified above. Projected units of service will be required upon issuance of an operating certificate for a new site or an amended operating certificate reflecting a change in capacity. Projected units of service shall be utilized for fee-setting purposes until a full-year cost report, subsequent to the cost report period in which the issuance of an operating certificate for a new site occurred, is used for fee-setting purposes. Projected units of service shall also be utilized for fee-setting purposes until a full-year cost report, subsequent to the cost report period in which the change in capacity occurred, is utilized for fee-setting purposes. If the estimated units of service have not been received by OMRDD by the date required, OMRDD shall utilize the units of service paid for through the MMIS, beginning with the program's initial certification or the first full month since the change in certified capacity occurred. If the available MMIS units of service are for less than a twelve month period, they shall be annualized for fee-setting purposes.

(2) The fee for Day Treatment programs shall be a fixed amount plus operating, capital and transportation component add-ons. The fixed amount and operating component add-ons shall reflect base period costs and shall be subject to trend factors as approved by the commissioner. All dollar amounts cited herein shall reflect costs for the base period of January 1, 1988 through December 31, 1988.

(i) The operating component add-ons shall be case mix, case mix intensity, salary, staff training and utilities. In addition, non-state operated Day Treatment programs that have submitted cost reports that contain full year costs for the periods January 1, 1988 through December 31, 1988, and July 1, 1988 through June 30, 1989, and state operated Day Treatment programs which have submitted cost reports that contain full year costs for the period April 1, 1989 through March 31, 1990 shall be eligible to qualify for either a cap adjustment component add-on or an allocation adjustment component add-on. In addition, non-state operated Day Treatment programs in Regions II and III that participated in the Salary Enhancement plan pursuant to previously approved State Plan Amendment 88-48 shall also receive a salary enhancement cost adjustment component add-on. Operating component add-ons shall reflect base year costs and shall be subject to a trend factor.

(ii) The capital component shall include property, equipment, and start-up costs. The capital component will not be subject to trend factor.

(iii) Non-state operated Day Treatment programs in Regions II and III including those non-state operated Day Treatment programs in Region I designated or elected to a Region II or III reporting year end and fiscal cycle shall also receive an annualization cost component add-on for the period April 1, 1991 through December 31, 1991.

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(iv) The fixed amount shall be $36.67. Effective July 1, 1996, the product of the administration component of the fixed fee times the units of service shall be reduced by an efficiency adjustment as described in this Attachment at subsection (9).

(v) Effective July 1, 1996, there shall be a separate transportation component add-on to the program's fee as described in this Attachment at subsection (10).

(vi) The operating component add-ons shall be computed. Such component add-ons shall be added to the fixed amount.

(a) Case Mix Component - The Developmental Disabilities Profile (DDP) shall be completed for each person attending the Day Treatment program. The individual's adaptive, maladaptive, and health/medical DDP scores shall be assigned as appropriate to its corresponding DDP percentile level grouping. The case mix component add-on will be calculated utilizing the